

		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0037143</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Illini Hospital Nursing Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2001</u> to <u>06/30/2002</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>1455 Hospital Road</u> <u>Silvis</u> <u>61282</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Rock Island</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Barbara Mask</u> (Title) <u>Administrator</u>	
Telephone Number: <u>(309) 792-7614</u> Fax # <u>(309) 792-7611</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>Jill R. Jost, CPA</u> <u>Reimbursement Analyst</u> (Firm Name & Address) <u>Genesis Health System</u> <u>1227 E. Rusholme St., Davenport, IA 52803</u> (Telephone) <u>(563) 421-1996</u> Fax # <u>(563) 421-1999</u>	
IDPA ID Number: <u>36-3616314001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>08/12/1991</u>			
Type of Ownership:			
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT			
<input checked="" type="checkbox"/> Charitable Corp.		<input type="checkbox"/> PROPRIETARY	
<input type="checkbox"/> Trust		<input type="checkbox"/> Individual	
IRS Exemption Code _____		<input type="checkbox"/> Partnership	
		<input type="checkbox"/> Corporation	
		<input type="checkbox"/> "Sub-S" Corp.	
		<input type="checkbox"/> Limited Liability Co.	
		<input type="checkbox"/> Trust	
		<input type="checkbox"/> Other _____	
In the event there are further questions about this report, please contact: Name: <u>Jodie Criswell</u> Telephone Number: <u>(309) 792-4268</u>			

STATE OF ILLINOIS

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Facility Name & ID Number Illini Hospital Nursing Home# 0037143 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds 08/11/2001

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>67</u>	Skilled (SNF)	<u>67</u>	<u>24,455</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>53</u>	Sheltered Care (SC)	<u>53</u>	<u>19,345</u>	5
6		ICF/DD 16 or Less			6
7	<u>120</u>	TOTALS	<u>120</u>	<u>43,800</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF		<u>230</u>	<u>6,929</u>	<u>7,159</u>	8
9	SNF/PED					9
10	ICF	<u>5,210</u>	<u>10,220</u>		<u>15,430</u>	10
11	ICF/DD					11
12	SC		<u>14,944</u>		<u>14,944</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>5,210</u>	<u>25,394</u>	<u>6,929</u>	<u>37,533</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 85.69%

D. How many bed-hold days during this year were paid by Public Aid?

23 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 08/12/1991

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 08/12/1991 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 22 and days of care provided 7,158Medicare Intermediary Cahaba GBA

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 06/30/02 Fiscal Year: 06/30/02

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number

Illini Hospital Nursing Home

0037143

Report Period Beginning:

07/01/2001

Ending:

06/30/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary											1
2	Food Purchase		567,966		567,966		567,966	(106,396)	461,570			2
3	Housekeeping		11,643	193,788	205,431		205,431	41,903	247,334			3
4	Laundry											4
5	Heat and Other Utilities			103,032	103,032		103,032		103,032			5
6	Maintenance		20,829	157,625	178,454		178,454	(96,046)	82,408			6
7	Other (specify):*											7
8	TOTAL General Services		600,438	454,445	1,054,883		1,054,883	(160,539)	894,344			8
	B. Health Care and Programs											
9	Medical Director			9,150	9,150		9,150		9,150			9
10	Nursing and Medical Records	1,619,230	25,796	56,554	1,701,580		1,701,580		1,701,580			10
10a	Therapy	44,400	594	323,744	368,738		368,738		368,738			10a
11	Activities	75,348	7,839	6,940	90,127		90,127		90,127			11
12	Social Services	61,418	92	1,800	63,310		63,310		63,310			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* Neuro & Lab		115	150	265		265		265			15
16	TOTAL Health Care and Programs	1,800,396	34,436	398,338	2,233,170		2,233,170		2,233,170			16
	C. General Administration											
17	Administrative	93,010	1,740	6,551	101,301		101,301		101,301			17
18	Directors Fees											18
19	Professional Services			63,325	63,325		63,325	1,119,601	1,182,926			19
20	Dues, Fees, Subscriptions & Promotions			7,516	7,516		7,516		7,516			20
21	Clerical & General Office Expenses	170,574	4,322	374,505	549,401		549,401		549,401			21
22	Employee Benefits & Payroll Taxes			376,132	376,132		376,132	23,111	399,243			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,866	7,866		7,866		7,866			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			274,876	274,876		274,876		274,876			26
27	Other (specify):* Acctg & Audit Fees			462,394	462,394		462,394		462,394			27
28	TOTAL General Administration	263,584	6,062	1,573,165	1,842,811		1,842,811	1,142,712	2,985,523			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,063,980	640,936	2,425,948	5,130,864		5,130,864	982,173	6,113,037			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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Facility Name & ID Number

Illini Hospital Nursing Home

#0037143

Report Period Beginning:

07/01/2001

Ending:

06/30/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation											30
31	Amortization of Pre-Op. & Org.											31
32	Interest			569,574	569,574		569,574	(95,172)	474,402			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			12,839	12,839		12,839		12,839			35
36	Other (specify):* Amort of Bonds			5,639	5,639		5,639		5,639			36
37	TOTAL Ownership			588,052	588,052		588,052	(95,172)	492,880			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		277,492		277,492		277,492		277,492			39
40	Barber and Beauty Shops			10,410	10,410		10,410	(10,410)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*				51,525		51,525	(51,525)				43
44	TOTAL Special Cost Centers		277,492	10,410	339,427		339,427	(61,935)	277,492			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,063,980	918,428	3,024,410	6,058,343		6,058,343	825,066	6,883,409			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Illini Hospital Nursing Home

0037143

Report Period Beginning:

07/01/2001

Ending:

06/30/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
NON-ALLOWABLE EXPENSES	Amount	Refer-	OHF USE	
		ence	ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals				4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space	(48,401)	19		6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation				9
10 Interest and Other Investment Income	(95,172)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees	(10,410)	40		17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(51,525)	43		24
25 Fund Raising, Advertising and Promotional				25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule	(988)	21		29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (206,496)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	1,030,574		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ 1,030,574		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ 824,078		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		x	\$		38
39					39
40 Gift and Coffee Shops		x			40
41 Barber and Beauty Shops		x			41
42 Laboratory and Radiology		x			42
43 Prescription Drugs		x			43
44 Exceptional Care Program		x			44
45 Other-Attach Schedule		x			45
46 Other-Attach Schedule		x			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

Illini Hospital Nursing Home

ID# 0037143

Report Period Beginning: 07/01/2001

Ending: 06/30/2002

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

06/30/2002

[illegible]

Summary B

06/30/2002

Summary B

[illegible]

Facility Name & ID Number Illini Hospital Nursing Home# 0037143Report Period Beginning: 07/01/2001 Ending: 06/30/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Illinois Nursing Home		Illini Restorative Care Center	Silvis, IL	Illini Hospital	Silvis, IL	Hospital
				Crosstown Square	Silvis, IL	Senior Apartments
				Genesis Health System	Davenport, IA	Home Office

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	2 Dietary Grocery 85010-370000	\$ 342,216	Illini Hospital (B, Pt I allocated cost)	100.00%	\$ 459,819	\$ 117,603 1
2	V	2 Dietary Grocery 85030-370000	223,999	Illini Hospital (B, Pt I allocated cost)	100.00%		(223,999) 2
3	V	3 Housekeeping 85510-54800	170,626	Illini Hospital (B, Pt I allocated cost)	100.00%	235,692	65,066 3
4	V	3 Housekeeping 85530-54800	23,163	Illini Hospital (B, Pt I allocated cost)	100.00%		(23,163) 4
5	V	6 Security 86710 & 86730-54800	13,132	Illini Hospital (B, Pt I allocated cost)	100.00%		(13,132) 5
6	V	19 Admin 80010-54800	56,734	Illini Hospital (B, Pt I allocated cost)	100.00%	1,228,420	1,171,686 6
7	V	19 Admin 80030-54800	3,684	Illini Hospital (B, Pt I allocated cost)	100.00%		(3,684) 7
8	V	21 Overhead Alloc 80010-69500	168,455	A-8-1 Home Office Cost Report	affiliated	168,455	
9	V	21 Overhead IT Alloc 80010-69550	83,627	A-8-1 Home Office Cost Report	affiliated	83,627	
10	V	21 Overhead Alloc 80030-69500	47,516	A-8-1 Home Office Cost Report	affiliated	47,516	
11	V	21 Overhead IT Alloc 80030-69550	23,587	A-8-1 Home Office Cost Report	affiliated	23,587	
12	V	22 Cafeteria		Illini Hospital (B, Pt I allocated cost)	100.00%	23,111	23,111 12
13	V	6 Maintenance 86010 & 86030-54800	82,914	Illini Hospital (B, Pt I allocated cost)	100.00%		(82,914) 13
14	Total		\$ 1,239,653			\$ 2,270,227	\$ * 1,030,574 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

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Facility Name & ID Number Illini Hospital Nursing Home # 0037143 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Illini Hospital Nursing Home# 0037143Report Period Beginning: 07/01/2001Ending: 6/30/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Illini HospitalStreet Address 801 Hospital RoadCity / State / Zip Code Silvis, IL 61282Phone Number (309) 792-4268Fax Number (309) 792-4274

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<u>2</u> Dietary Groceries	<u>Meals Served</u>	<u>320,369</u>	<u>3</u>	<u>\$ 2,070,993</u>	<u>\$ 537,149</u>	<u>71,131</u>	<u>\$ 459,819</u>	1
2	<u>3</u> Housekeeping	<u>Square Feet</u>	<u>156,813</u>	<u>3</u>	<u>1,323,530</u>	<u>639,330</u>	<u>27,925</u>	<u>235,692</u>	2
3	<u>19</u> Allocated Hospital Admin	<u>Accum. Cost</u>	<u>43,010,262</u>	<u>3</u>	<u>9,949,784</u>	<u>2,850,672</u>	<u>5,310,130</u>	<u>1,228,420</u>	3
4	<u>22</u> Allocated Café Costs	<u>Fte's Served</u>	<u>37,588</u>	<u>3</u>	<u>157,029</u>	<u>20,390</u>	<u>5,532</u>	<u>23,111</u>	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 13,501,336	\$ 4,047,541		\$ 1,947,042	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Pacific Commonwealth		x	Building Construction		4/99	\$ 8,816,721	\$ 8,739,676	11/01/40	6.5000	\$ 569,842	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 8,816,721	\$ 8,739,676			\$ 569,842	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 8,816,721	\$ 8,739,676			\$ 569,842	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 78,305 Line # 26

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Illini Hospital Nursing Home**# **0037143** Report Period Beginning: **07/01/2001** Ending: **06/30/2002****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2001 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1997	8		
	1998	9		
	1999	10		
	2000	11		
	2001	12		
			FOR OHF USE ONLY	
			13	FROM R. E. TAX STATEMENT FOR 2001 \$ 13
			14	PLUS APPEAL COST FROM LINE 5 \$ 14
			15	LESS REFUND FROM LINE 6 \$ 15
			16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Illini Hospital Nursing Home COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0037143

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

A. Square Feet: 57,055

B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred: _____

2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____

4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home	157,252	1991	\$ 13,074	1
2	Nursing Home	63,650	1999	20,368	2
3	TOTALS	220,902		\$ 33,442	3

Facility Name & ID Number Illini Hospital Nursing Home

0037143

Report Period Beginning:

07/01/2001 Ending: 06/30/2002

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	67			1991	\$ 1,933,738	\$ 72,168	40	\$ 72,168		\$ 971,695	4
5	53			2000	5,239,215	130,980	40	130,980		244,218	5
6											6
7											7
8											8
	Improvement Type**										
9	Land Improvement - 10 year #1, #2, #102, #189			1991	12,671		10			12,671	9
10	Land Improvement - 15 year #187			1991	27,738	1,849	15	1,849		20,803	10
11	Carpet #239			1992	438		5			438	11
12	Vinyl Floorings #240			1992	578	29	20	29		275	12
13	Chandelier #241			1992	492	49	10	49		475	13
14	Wallpaper #244			1992	3,326		5			3,326	14
15	Signage #243			1993	1,305	109	12	109		1,025	15
16	Alarm System #247			1992	587	39	15	39		374	16
17	Smoke Door Hood #249			1992	779	78	10	78		760	17
18	Central Dumpster #250			1992	465	47	10	47		465	18
19	New Seeding/Mulch #261, #262			1993	12,415	1,243	10	1,243		11,075	19
20	Repair Sidewalk #274			1994	1,874	125	15	125		1,041	20
21	Circuit Panel A/C Outlet #265			1993	930	93	10	93		822	21
22	Install A/C #275			1994	498	50	10	50		416	22
23	FY95 Additions #278, #292, #294			1995	7,072	504	15	504		3,886	23
24	PT Therapy Utility Construction #305			1996	142,757	9,517	15	9,517		68,999	24
25	Canvas Awning #306 & Decorative Lighting #307			1996	29,660	1,848	15	1,848		11,270	25
26	Emerson #308			1996	594	59	10	59		429	26
27	Parking Lot Repair #317			1997	3,561	445	5	445		2,522	27
28	Major Repair IRC Boiler #319			1997	9,872	657	7	657		9,872	28
29	Directory Board #327			1997	797	79	5	79		478	29
30	Remodel IRC Nurse Station #330			1997	3,340	222	15	222		1,150	30
31	Cabinets-Storage-Utility Room #331			1997	4,103	273	15	273		1,412	31
32	Carpet #329			1997	1,440		5			1,440	32
33	Hot Water Tank #328			1997	1,749	175	5	175		1,049	33
34	Tank #312			1996	2,650	265	10	265		1,656	34
35	Air Compressor for Chiller #335			1997	14,196	947	15	947		4,338	35
36											

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Double Egress Doors #341	1998	\$ 2,756	\$ 183	15	\$ 183	\$	\$ 763		37
38	Landscaping #352	1999	2,176	218	10	218		763		38
39	Carpet Lobby & Office Areas #361	1999	3,123	625	5	625		2,187		39
40	Tie-In Piping Hot Water to IRC #372	1999	1,766	88	20	88		308		40
41	Install VPI Base & Ceramic Tile #376	1999	1,385	139	10	139		486		41
42	Lock Sets Mastered to Key #349	1999	2,642	528	5	528		1,848		42
43	Wood Replacement Doors #388	2000	1,308	88	15	88		218		43
44	4" Sprinkler System #397	2000	18,675	747	25	747		1,868		44
45	Concrete Replacement #444	2001	2,239	149	15	149		224		45
46	IRC Roof Hatches #435	2001	2,420	242	10	242		363		46
47	Door and Door Closers Exam Room #440	2001	1,524	102	15	102		153		47
48	Activities Office-Paint, Wallpaper, Carpet #442	2001	1,926	385	5	385		578		48
49	Carpentry Patient Room Showers #443	2001	9,326	622	15	622		933		49
50	Air Cond/Handling Unit 3-Way Control Val #433	2001	2,187	219	10	219		328		50
51	IRC Boiler Stack #438	2001	14,750	738	20	738		1,107		51
52	PA System IRC Dining Room #439	2001	1,682	168	10	168		252		52
53	Date Voice Wiring-SC #412	2001	31,453	3,145	10	3,145		4,718		53
54	Door Alarm - SC #413	2001	2,211	221	10	221		332		54
55	Analog Message-SC #414	2001	2,693	269	10	269		404		55
56	Phone System-SC	2001	25,643	2,564	10	2,564		3,846		56
57	Nurse Call System - SC #436	2001	6,498	650	10	650		975		57
58	Kitchen Cabinets-SC #437	2001	4,077	272	15	272		408		58
59	Refrigerator, Washer, Dryer - SC #422, #423, #424	2001	1,665	185	10	185		278		59
60	Phones - SC #426, #427, #428	2001	4,224	845	5	845		1,267		60
61	Beauty Shop - SC #425	2001	1,621	162	10	162		243		61
62	Parking Lot - NW Area-Asphalt & Lights #462, #463	2002	53,929	3,251	10	3,251		3,251		62
63	IRC Bldg Improv #451, #453, #454, #455, #456, #510	2002	17,485	766	10	766		766		63
64	IRC Hallway Carpet #464	2002	10,072	1,007	5	1,007		1,007		64
65	IRC Wooden Door #445, Bedpan Washers #450	2002	4,388	146	15	146		146		65
66	IRC Switchboard cable #458, Boiler Fail over #461	2002	6,736	337	10	337		337		66
67		2002								67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 7,701,420	\$ 240,911		\$ 240,911	\$	\$ 1,408,737		70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 743,445	\$ 33,855	\$ 33,855	\$	10	\$ 413,408	71
72	Current Year Purchases	27,797	1,546	1,546		10	1,546	72
73	Fully Depreciated Assets							73
74	Disposal	(2,652)	(872)	(872)		10	(1,267)	74
75	TOTALS	\$ 768,590	\$ 34,529	\$ 34,529	\$		\$ 413,687	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	Van, Ford 1991	1991	\$ 33,800	\$	\$	\$		\$ 33,800	76
77										77
78										78
79										79
80	TOTALS			\$ 33,800	\$	\$	\$		\$ 33,800	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,537,252	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 275,440	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 275,440	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,856,224	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 12,839 Description: PT, Nursing Admin, Nursing Floor, Maintenance Rental

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2003 \$ _____

13. /2004 \$ _____

14. /2005 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist	10a, 1-3	hrs	\$		
2	Licensed Speech and Language Development Therapist	10a, 1-3	hrs			8,640	7			8,647	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10a, 1-3	hrs	44,400		315,104	291			359,795	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39	# of prescrpts				151,462			151,462	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								
10	Academic Education		hrs								10
11	Exceptional Care Program										11
12											12
13	Other (specify): Charge Med Supplies	39					126,030			126,030	13
14	TOTAL			\$ 44,400		\$ 323,744	\$ 278,086		\$	646,230	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,689,719	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	480,631		3
4	Supply Inventory (priced at)	2,316		4
5	Short-Term Investments	9,179		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	635		7
8	Accounts Receivable (owners or related parties)	(637,997)		8
9	Other(specify): <u>Misc Rec'bles</u>	5,068		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,549,551	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	33,442		13
14	Buildings, at Historical Cost	7,675,124		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	828,686		16
17	Accumulated Depreciation (book methods)	(1,856,224)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,054,157		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,735,185	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,284,736	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 39,003	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	214,938		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Third Party Settlements</u>	299,911		36
37	<u>Employee Health Benefit Claims</u>	91,000		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 644,852	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	8,739,676		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 8,739,676	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,384,528	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (99,792)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,284,736	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 218,065	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 218,065	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(317,857)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (317,857)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (99,792)	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,208,255	1
2	Discounts and Allowances for all Levels	(2,020,889)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,187,366	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,426,927	6
7	Oxygen	69,172	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,496,099	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	20,008	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	48,401	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	67,288	18
19	Laboratory	73,546	19
20	Radiology and X-Ray	19,864	20
21	Other Medical Services	5,150	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 234,257	23
D. Non-Operating Revenue			
24	Contributions	4,094	24
25	Interest and Other Investment Income***	93,994	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 98,088	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	988	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 988	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,016,798	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,054,883	31
32	Health Care	2,233,170	32
33	General Administration	1,842,811	33
B. Capital Expense			
34	Ownership	864,364	34
C. Ancillary Expense			
35	Special Cost Centers	339,427	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,334,655	40
41	Income before Income Taxes (line 30 minus line 40)**	(317,857)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (317,857)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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Facility Name & ID Number Illini Hospital Nursing Home# 0037143Report Period Beginning: 07/01/2001Ending: 06/30/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,866	2,080	\$ 54,205	\$ 26.06	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,822	16,246	306,125	18.84	3
4	Licensed Practical Nurses	24,918	27,296	418,802	15.34	4
5	Nurse Aides & Orderlies	67,840	75,317	739,570	9.82	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,891	2,162	42,005	19.43	7
8	Rehab/Therapy Aides	3,407	3,876	43,616	11.25	8
9	Activity Director	2,045	2,285	29,636	12.97	9
10	Activity Assistants	4,895	5,419	47,264	8.72	10
11	Social Service Workers	3,630	4,113	40,692	9.89	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,928	2,280	102,536	44.97	20
21	Assistant Administrator					21
22	Other Administrative	3,856	4,294	83,337	19.41	22
23	Office Manager					23
24	Clerical	4,319	4,739	53,453	11.28	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,988	2,139	23,719	11.09	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Staff Devel Coord</u>	1,609	1,899	36,039	18.98	33
34	TOTAL (lines 1 - 33)	139,014	154,145	\$ 2,020,999 *	\$ 13.11	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
Barbara Mask			\$ 93,010	Workers' Compensation Insurance		\$	IDPH License Fee	\$
				Unemployment Compensation Insurance			Advertising: Employee Recruitment	
				FICA Taxes		154,052	Health Care Worker Background Check (Indicate # of checks performed _____)	
				Employee Health Insurance		133,772	Dues & Subscriptions	7,364
				Employee Meals			Advertising 84710-62000	0
				Illinois Municipal Retirement Fund (IMRF)*			Advertising 68110-62000	152
				Pension Expense 87110-20500		63,334		
				Life Insurance 87110-21000		5,048		
				Disability 87110-21100		10,975		
				EAP 87110-21300, 87130-21300		2,467		
				EE Physicals 87110-22000		3,049		
				Misc Benefits 87110-24990		3,435	Less: Public Relations Expense	(
				Cafeteria Adjustment - page 6		23,111	Non-allowable advertising	(
							Yellow page advertising	(
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 93,010	TOTAL (agree to Schedule V, line 22, col.8)		\$ 399,243	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 7,516
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Other 80010-69990			\$ 6,551			\$	Out-of-State Travel	\$
							In-State Travel	2,301
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 6,551				Seminar Expense	5,585
C. Professional Services								
Vendor/Payee	Type		Amount					
Illini Hospital 80010-54800	Management Svc		\$ 56,734				Entertainment Expense	(
Illini Hospital 80010-45000	Professional		2,907				(agree to Sch. V, line 24, col. 8)	
Illini Hospital 80030-45000	Professional		0				TOTAL	\$ 7,886
Illini Hospital 80030-54800	Management Svc		3,684					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 63,325	TOTAL		\$		

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number Illini Hospital Nursing Home

STATE OF ILLINOIS

0037143

Report Period Beginning: 07/01/2001

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Ending: 06/30/2002

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council on LTC \$3704
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 21,773 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 0
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 23,111 Has any meal income been offset against related costs? net in allocat Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: McGladrey & Pullen, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not yet complete. Will send ASAP.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Illini Nursing Home d/b/a Illini Restorative Care
#0037143
Attachment to Financial and statistical Report for Long-Term Care Facilities

Please note that Line 30, Column 3 on Schedule V would not accept a depreciation amount. Per our general ledger this amount is \$276,312. We have included this amount in the total expense amounts on page 19, Line 34.

Please note the following supporting itemization for Schedule V, Line 27, Column 3.

80010-41000	Auditing Fees	14,384
80010-41050	Accounting Fees-Related	297,458
80010-41070	Accounting Fees	12,617
80010-41500	Legal Fees	150
80030-41000	Auditing Fees	12,714
80030-41050	Accounting Fees - Related	112,232
80030-41070	Accounting Fees	<u>12,838</u>
		462,394